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PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Name: _____ **Date:** _____
Last First Preferred Name

Address: _____
Street Apartment #

_____
City State Zip Code

Email: _____ **Gender:** ❑ Male ❑ Female **Family Status:** ❑ Single ❑ Married ❑ Child

Social Security #: _____ **Birth Date:** _____

Driver's License #: _____ ***** Office Use Only *****

**** HIPPA **** Do we have your permission to leave appointment, billing or dental information on your answering machine, voicemail or e-mail at the following numbers? Please check "Yes" or "No" for each contact number.

Home Phone: _____ ❑ Yes ❑ No **Best time to call:** _____
Work: _____ ❑ Yes ❑ No **Best time to call:** _____
Cell Phone: _____ ❑ Yes ❑ No **Best time to call:** _____
Cell Text Message: _____ ❑ Yes ❑ No
E-mail: _____

Employer: _____ **Occupation:** _____
Employer Address: _____
In case of an emergency, contact: _____ **Phone:** _____ **Relation:** _____

RESPONSIBLE PARTY / GUARANTOR INFORMATION

Only if the person responsible is NOT the patient, complete the following information for the Guarantor.

Guarantor Name: _____
Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other
Gender: ❑ Male ❑ Female **Family Status:** ❑ Single ❑ Married ❑ Child ❑ Divorced
Address: _____
Street City State Zip Code
Social Security #: _____ **Birth Date:** _____
Driver's License #: _____ ***** Office Use Only *****
Phone Numbers: Home: _____ Cell: _____ Email: _____
Employer Name: _____ **Occupation:** _____
Employer Address: _____
Street City State Zip Code

REFERRAL INFORMATION

How did you learn about, or who referred you to our dental office? ❑ Patient / Friend ❑ Our Staff ❑ Another Dental Office ❑ Insurance Plan ❑ Website ❑ Newsletter ❑ School ❑ Your Employer ❑ Other

Name of person, dental or medical office that referred you: _____

PATIENT'S HEALTH INFORMATION

Date of last Dental Visit: _____ Reason for visit: _____

Have you ever had any of the following health problems, conditions or habits?

Y	N		Y	N		Y	N		Y	N	
☐	☐	AIDS	☐	☐	Jaundice	☐	☐	Kidney Disease	☐	☐	Stomach Problems
☐	☐	Allergy (Codeine)	☐	☐	Diabetes	☐	☐	Liver Disease	☐	☐	Stroke
☐	☐	Allergy (Penicillin)	☐	☐	Dizziness	☐	☐	Mental Disorders	☐	☐	Swelling feet / ankles
☐	☐	Allergy (Other)_____	☐	☐	Epilepsy	☐	☐	Mitral Valve	☐	☐	Substance Abuse
☐	☐	Anemia	☐	☐	Excessive Bleeding	☐	☐	Nervous Disorders	☐	☐	Thyroid Problems
☐	☐	Arthritis, Rheumatism	☐	☐	Fainting	☐	☐	Pacemaker	☐	☐	Tobacco Habit
☐	☐	Artificial Heart Valves	☐	☐	Glaucoma	☐	☐	Pregnancy Due Date: _____	☐	☐	Tonsillitis
☐	☐	Artificial Joints, Pins	☐	☐	Growths	☐	☐	Tuberculosis	☐	☐	Tumors
☐	☐	Asthma	☐	☐	Hay Fever	☐	☐	Radiation Treatment	☐	☐	Ulcers
☐	☐	Back Problems	☐	☐	Headaches	☐	☐	Respiratory Problems	☐	☐	Venereal Disease
☐	☐	Bleeding Abnormally	☐	☐	Head Injuries	☐	☐	Rheumatic Fever	☐	☐	Other:
☐	☐	Blood Disease	☐	☐	Heart Disease	☐	☐	Rheumatism			
☐	☐	Cancer	☐	☐	Heart Murmur	☐	☐	Scarlet Fever			
☐	☐	Chemical Dependency	☐	☐	Hemophilia	☐	☐	Sexually Transmitted Disease (Including HIV / Aids)			
☐	☐	Circulatory Problems	☐	☐	Hernia Repair	☐	☐	Shortness of Breath			
☐	☐	Congenital Heart Defect	☐	☐	Sinus Problems	☐	☐	Cough up blood			
☐	☐	High Blood Pressure	☐	☐	Skin Rash	☐	☐	Cough, Persistent			
☐	☐	Cortisone Treatments	☐	☐	Jaw Pain	☐	☐	Smoking _____ / day _____/year			

Have you ever had any if the following dental problems or conditions? Please check those that apply:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Bad Breath	☐	☐	Grinding or Clenching Teeth	☐	☐	Sensitivity to sweets	☐	☐	Nitrous Oxide
☐	☐	Bad Taste	☐	☐	Loose Teeth	☐	☐	Sensitivity to Hot	☐	☐	Prolonged Bleeding
☐	☐	Bleeding Gums	☐	☐	Broken Fillings	☐	☐	Sensitivity when Biting	☐	☐	General Anesthetic
☐	☐	Clicking / Popping of Jaw	☐	☐	Periodontal Treatment	☐	☐	Sores / Growth in the Mouth	☐	☐	Extractions
☐	☐	Food caught in teeth	☐	☐	Sensitivity to Cold	☐	☐	Braces	☐	☐	Local Anesthetic - Novocain

Please answer the following dental / medical questions:

- Have you ever been, or do you need to be, Pre-Medicated for dental work? ❑ Yes ❑ No
- How often do you brush and/or floss? _____
- Have you ever worn dentures or partials? ❑ Yes ❑ No If so, how old are they? _____
- Do you want whiter teeth? ❑ Yes ❑ No
- Do you want straighter teeth? ❑ Yes ❑ No
- Do you chew on one side? ❑ Yes ❑ No
- Have you ever had any complications following dental treatment? ❑ Yes ❑ No
- If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ❑ Yes ❑ No
- If yes, please explain: _____
- Are you pregnant? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No
- Are you taking birth control pills? ❑ Yes ❑ No
- **Are you now under the care of a physician?** ❑ Yes ❑ No
- **If yes, please Explain:** _____
- **Name of Physician:** _____ **Phone:** _____
- **Do you have any health problems that need further clarification**? ❑ Yes ❑ No
- **If yes, please explain:** _____

Please list <u>ALL MEDICATIONS</u> currently being taken and the related diagnosis or medical condition:

_____

_____

_____

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Elan Salee D.M.D., P.A. (DBA Boynton Dental Studio)
TERMS AND CONDITIONS OF SERVICE

In consideration of all services provided by **Elan Salee D.M.D., P.A. (DBA Boynton Dental Studio)** and its employees, contractors and/or affiliates, the undersigned hereby acknowledges and agrees 9(on behalf of himself or herself and his or her children, dependents and other persons for whom he or she serves as guarantor (collectively, "Dependents") with the following terms and conditions of service:

Medical Information. The undersigned hereby certifies that all information provided to Elan Salee D.M.D., P.A. is true, correct and complete and agrees promptly inform Elan Salee D.M.D., P.A. of any changes in any information (including regarding any Dependent). Elan Salee D.M.D., P.A. is authorized to use and disclose to any insurance, billing, management or processing company, agency or organization any health care information/medical records relating to the undersigned or any Dependent to obtain payment for services, determine insurance benefits or otherwise as required by law. Elan Salee D.M.D., P.A. is authorized to contact the undersigned at any telephone number provided above (unless otherwise revoked in writing) to discuss this form and any billing, treatment, or other matter related to any dental treatment (including for any Dependent).

Treatment; Informed Consent. The undersigned authorizes Elan Salee D.M.D., P.A. and any treating dentist, hygienist and/or staff to perform all treatment described in any treatment plan (and including all other services determined by such dentist to be necessary or appropriate in connection with such treatment plan) accepted by undersigned for himself/herself or any dependent. Dentistry is a biological procedure and not an exact science; therefore, despite the highest standard of care, no guarantee is or can be given by Elan Salee D.M.D., P.A. or any dentist or any other person employed or contracted by Elan Salee D.M.D., P.A. regarding any treatment or the results that may be obtained. The patient must comply with all specified appointments, procedures and continuing care and failure to do so will adversely affect the patient's treatment often necessitating additional required treatment (or retreatment) with additional fees. Failure to show in 15 minutes of the scheduled time for, or provide at least 48 hours advance notice of cancellation of, any appointment for any reason will result in a broken appointment fee. Elan Salee D.M.D., P.A. does not exercise control over the professional services of any of its treating dentists; therefore, the undersigned shall solely hold the treating dentist responsible for any treatment performed (including, without limitation, treatment provided under the treating dentist's supervision) and agrees to hold Elan Salee D.M.D., P.A. and its officers, directors, owners and affiliates harmless from any claim, suit, loss or damage related to any dental treatment. Fees in treatment plans for non-insurance/discount plan patients are only valid for 30 days; all insurance/discount plan fees are subject to change at any time based upon changes in plan fee schedules or to correct errors.

Financial Responsibility; Insurance. **THE UNDERSIGNED PATIENT AND/OR GUARANTOR ASSUME FULL RESPONSIBILITY FOR PAYMENT OF ALL FEES AND CHARGES FOR ALL SERVICES OF ELAN SALEE D.M.D., P.A. (DBA: BOYNTON DENTAL STUDIO), WHETHER OR NOT COVERED BY INSURANCE, THE PATIENT'S PORTION OF ALL FEES (INCLUDING ALL DEDUCTIBLES AND CO-PAYS) IS DUE AND PAYABLE IN FULL AT THE TIME SERVICES ARE PERFORMED** (for treatment involving multiple appointments, such as a crown, root canal, denture or implant, the entire patient portion is normally due when treatment is started). Any special financial arrangements must be made before treatment is started, all insurance, discount plans and discount coupons must be presented before treatment is started. Elan Salee D.M.D., P.A. submits insurance claims solely to primary dental insurance for patients' convenience and does not assume responsibility for the processing of such insurance or failure of insurance to pay for any reason. **Dental insurance rarely covers all fees; estimated or preauthorized insurance benefits are not guaranteed.** The undersigned agrees to promptly pay on demand any balance not paid by insurance within 60 days after the date of service. A service charge of 1 ½% per month (18% per annum) is charged on all balances more than 30 days past due. Insurance balances are considered past due if not paid within the 60 days after the date of service. The undersigned shall pay all costs incurred by Elan Salee D.M.D., P.A. relating to collection of any unpaid or delinquent balance (including, without limitation, attorneys and collection agency fees, court costs, paralegals) whether or not suit is filed. Elan Salee D.M.D., P.A. reserves the right to terminate or deny any treatment if the patient's account is delinquent.

Assignment of Benefits; Authorization and Release. The undersigned hereby certifies that all insurance coverage described above is current and valid and assigns directly to Elan Salee D.M.D., P.A. all insurance benefits covering the undersigned or any Dependent for all services rendered. The undersigned hereby agrees that his/her signature below will be maintained "on file"; Elan Salee D.M.D., P.A. (DBA Boynton Dental Studio) is authorized to use such signature on all applicable insurance claims and submissions. If any insurance payment is made to the undersigned, he/she will immediately remit such payment to Elan Salee D.M.D., P.A.

Notice of Privacy Practices. The undersigned has reviewed a copy of Elan Salee D.M.D., P.A. (DBA Boynton Dental Studio) notice of Privacy Practices effective April 14, 2003, as amended.

I have read the above terms and conditions of service by Elan Salee D.M.D., P.A. (DBA Boynton Dental Studio and understand and accept such terms:

_____ Date: _____ Witness: _____
Signature of Patient

_____ Date: _____ Relationship to Patient: _____
Signature of Responsible Party/ Guarantor (For minors, parent or legal guardian must sign)

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HIPPA COMPLIANCE

Patient's Name: *(Please Print)* _____
LAST NAME FIRST NAME MIDDLE

1. Do we have permission to send recall/treatment appointment reminders to your home? ❑ Yes ❑ No

2. Do we have your permission to leave the following information on your home answering machine or voicemail?

   Appointment Confirmation ❑ Yes ❑ No
   Billing Information ❑ Yes ❑ No
   Dental/Medical information ❑ Yes ❑ No

3. Do we have your permission to leave the following information on your work answering machine or voicemail?

   Appointment Confirmation ❑ Yes ❑ No
   Billing Information ❑ Yes ❑ No
   Dental/Medical information ❑ Yes ❑ No

4. Do we have your permission to send the following information to your e-mail address provided to us on your patient registration form?

   Appointment Confirmation ❑ Yes ❑ No
   Billing Information ❑ Yes ❑ No
   Dental/Medical information ❑ Yes ❑ No

5. Do we have your permission to send the following information to your cell phone number (including text messages) provided to us on your patient registration form?

   Appointment Confirmation ❑ Yes ❑ No
   Billing Information ❑ Yes ❑ No
   Dental/Medical information ❑ Yes ❑ No

6. Do we have your permission to send the following information to your fax machine at the number provided to us on your patient registration form?

   Appointment Confirmation ❑ Yes ❑ No
   Billing Information ❑ Yes ❑ No
   Dental/Medical information ❑ Yes ❑ No

7. I hereby give permission to share any information concerning me with the person(s) named below:

   Name: _____ Name: _____

DATE: _____
SIGNED: _____ **WITNESS:** _____
Print Name: _____ Print Name: _____
Relationship to Patient: ❑ **Self** ❑ **Spouse** ❑ **Parent** ❑ **Child** ❑ **Legal Guardian** ❑ **Other:**

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PHARMACY INFORMATION

House Bill 831 (2019), Electronic Prescribing, was signed into law by Governor DeSantis. The effective date is January 1, 2020.

The bill provides important new requirements for prescribers to generate and transmit all prescriptions electronically.

Patient Name: _____

Name of Pharmacy: _____

Address / Crossroads: _____

City: _____

Phone Number: _____

All information entered above is for office use only.